FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038877

Facility Name: FOX RIVER PAVILION

Address: 400 NEW YORK STREET (Number) AURORA (City) 60505 (Zip Code)

County: KANE

Telephone Number: (630) 897-8714 **Fax #** (630) 897-7123

IDPA ID Number: 363890248001

Date of Initial License for Current Owners: 06/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) MARVIN FOX, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,165	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,740	1,255	1,651	18,646	8
9	SNF/PED					9
10	ICF	19,947	497	141	20,585	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,687	1,752	1,792	39,231	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.83%

D. How many bed-hold days during this year were paid by Public Aid?
19 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 1,651

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	174,222	13,111		187,333		187,333	527	187,860			1
2	Food Purchase		202,252		202,252	(21,221)	181,031	(90)	180,941			2
3	Housekeeping	140,480	19,407		159,887		159,887		159,887			3
4	Laundry	72,002	15,615		87,617		87,617		87,617			4
5	Heat and Other Utilities			121,216	121,216		121,216	1,752	122,968			5
6	Maintenance	74,395		57,456	131,851		131,851	(8,575)	123,276			6
7	Other (specify):*							607	607			7
8	**TOTAL General Services**	461,099	250,385	178,672	890,156	(21,221)	868,935	(5,779)	863,156			8
	B. Health Care and Programs											
9	Medical Director			11,588	11,588		11,588		11,588			9
10	Nursing and Medical Records	1,384,975	90,103	138,041	1,613,119		1,613,119	19,542	1,632,661			10
10a	Therapy	20,851	3,129	2,723	26,703		26,703	(234)	26,469			10a
11	Activities	61,968	4,514		66,482		66,482		66,482			11
12	Social Services	76,972		9,838	86,810		86,810		86,810			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							3,058	3,058			15
16	**TOTAL Health Care and Programs**	1,544,766	97,746	162,190	1,804,702		1,804,702	22,366	1,827,068			16
	C. General Administration											
17	Administrative	60,972		171,989	232,961		232,961	(48,357)	184,604			17
18	Directors Fees											18
19	Professional Services			107,540	107,540	(59)	107,481	9,924	117,405			19
20	Dues, Fees, Subscriptions & Promotions			62,568	62,568		62,568	(36,387)	26,181			20
21	Clerical & General Office Expenses	116,991	40,916	199,630	357,537		357,537	(14,280)	343,257			21
22	Employee Benefits & Payroll Taxes			383,149	383,149	21,221	404,370	(2,132)	402,238			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,487	3,487		3,487	1,313	4,800			24
25	Other Admin. Staff Transportation			5,309	5,309		5,309	(2,648)	2,661			25
26	Insurance-Prop.Liab.Malpractice			102,718	102,718		102,718	2,043	104,761			26
27	Other (specify):*							29,612	29,612			27
28	**TOTAL General Administration**	177,963	40,916	1,036,390	1,255,269	21,162	1,276,431	(60,912)	1,215,519			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,183,828	389,047	1,377,252	3,950,127	(59)	3,950,068	(44,325)	3,905,743			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FOX RIVER PAVILION #0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			49,201	49,201		49,201	114,012	163,213			30
31	Amortization of Pre-Op. & Org.							43,520	43,520			31
32	Interest			42,830	42,830		42,830	203,782	246,612			32
33	Real Estate Taxes			122,778	122,778	59	122,837		122,837			33
34	Rent-Facility & Grounds			445,242	445,242		445,242	(430,222)	15,020			34
35	Rent-Equipment & Vehicles			5,083	5,083		5,083	823	5,906			35
36	Other (specify):*											36
37	**TOTAL Ownership**			665,134	665,134	59	665,193	(68,085)	597,108			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,229	199,319	322,548		322,548	(2,204)	320,344			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,247	66,247		66,247		66,247			42
43	Other (specify):*	35,492		2,119	37,611		37,611	(37,611)				43
44	**TOTAL Special Cost Centers**	35,492	123,229	267,685	426,406		426,406	(39,815)	386,591			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,219,320	512,276	2,310,071	5,041,667		5,041,667	(152,226)	4,889,441			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,975)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,686	30		9
10	Interest and Other Investment Income	(368)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(90)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,191)	25		19
20	Contributions	(2,468)	20		20
21	Owner or Key-Man Insurance	(2,132)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,000)	21		24
25	Fund Raising, Advertising and Promotional	(33,996)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(175)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,659)	20		28
29	Other-Attach Schedule	(79,594)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (214,963)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	62,737		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 62,737		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (152,226)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

FOX RIVER PAVILION

ID# 0038877

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (35,492)	43	1
2				2
3	BANK CHARGES	(3,663)	21	3
4	TRUST FEES	(2,250)	21	4
5	ICLTC COPE DUES	(600)	20	5
6	NON-ALLOWABLE LEGAL	(2,303)	19	6
7	MARKETING TRAVEL	(2,869)	43	7
8	PARKING TICKET	(95)	20	8
9	NON-ALLOWABLE TRAVEL	(1,486)	25	9
10	CAPITALIZED R&M	(9,142)	06	10
11	NON-ALLOWABLE FINANCING FEE	(1,523)	21	11
12	LATE PAYMENT INTERIST FEE	(2,452)	32	12
13	FINANCING FEES - BLDG CO	(18,519)	36	13
14				14
15				15
16				16
17				17
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95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(79,594)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				763		(236)						527	1
2	Food Purchase	(90)											(90)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities					1,752							1,752	5
6	Maintenance	(9,142)				567							(8,575)	6
7	Other (specify):*						607						607	7
8	**TOTAL General Services**	(9,232)			763	2,319	371						(5,779)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(2,433)	21,975							19,542	10
10a	Therapy			36			(270)						(234)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*					3,058							3,058	15
16	**TOTAL Health Care and Programs**			36	(2,433)	25,033	(270)						22,366	16
	C. General Administration													
17	Administrative					106,636		(154,993)					(48,357)	17
18	Directors Fees													18
19	Professional Services	(2,303)				10,912	(124,558)	125,873					9,924	19
20	Fees, Subscriptions & Promotions	(42,818)				6,379		52					(36,387)	20
21	Clerical & General Office Expenses	(102,586)				116,378		(28,072)					(14,280)	21
22	Employee Benefits & Payroll Taxes	(2,132)											(2,132)	22
23	Inservice Training & Education													23
24	Travel and Seminar					1,313							1,313	24
25	Other Admin. Staff Transportation	(2,677)				29							(2,648)	25
26	Insurance-Prop.Liab.Malpractice					2,145		(102)					2,043	26
27	Other (specify):*					27,533		2,079					29,612	27
28	**TOTAL General Administration**	(152,516)				271,325	(124,558)	(55,163)					(60,912)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(161,748)		36	(1,670)	298,677	(124,457)	(55,163)					(44,325)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,686	90,000			5,948		12,378					114,012	30
31	Amortization of Pre-Op. & Org.		43,520										43,520	31
32	Interest	(2,820)	203,034			1,596		1,972					203,782	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(445,242)			15,020							(430,222)	34
35	Rent-Equipment & Vehicles						823						823	35
36	Other (specify):*	(18,519)	18,519											36
37	**TOTAL Ownership**	(15,653)	(90,169)			22,564	823	14,350					(68,085)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			2,174	(4,378)								(2,204)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(37,561)					(50)						(37,611)	43
44	**TOTAL Special Cost Centers**	(37,561)		2,174	(4,378)		(50)						(39,815)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(214,963)	(90,169)	2,210	(6,048)	321,241	(123,684)	(40,813)					(152,226)	45

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRIAN CLOCH	50%	SEE ATTACHED		SEE ATTACHED		
MICHAEL FILIPPO	50%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 445,242	FOX RIVER PAVILION PARTNERSHIP		$	$ (445,242)	1
2	V	32	MORTGAGE INTEREST		FOX RIVER PAVILION PARTNERSHIP		203,034	203,034	2
3	V	30	DEPRECIATION		FOX RIVER PAVILION PARTNERSHIP		90,000	90,000	3
4	V	31	AMORTIZATION EXPENSE		FOX RIVER PAVILION PARTNERSHIP		43,520	43,520	4
5	V	36	FINANCE FEES		FOX RIVER PAVILION PARTNERSHIP		18,519	18,519	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 445,242			$ 355,073	$ * (90,169)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 2,453	Advanced Therapy and Rehab, LLC	100.00%	$ 2,489	$ 36	15
16	V	39	ANCILLARY REHAB	148,910	Advanced Therapy and Rehab, LLC	100.00%	151,084	2,174	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 151,363			$ 153,573	$ * 2,210	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 7,236	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 2,858	$ (4,378)	15
16	V	10	MEDICAL SUPPLIES	2,760	QUALITY CARE MEDICAL SUPPLY	100.00%	327	(2,433)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	763	763	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,996			$ 3,948	$ * (6,048)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 1,752	$ 1,752	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	567	567	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,945	8,945	17
18	V	10	SAL-NURSING-M. DEAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	13,030	13,030	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,058	3,058	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,221	7,221	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	22,469	22,469	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,765	8,765	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	19,406	19,406	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	11,456	11,456	24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	15,039	15,039	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	18,752	18,752	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,528	3,528	27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	10,912	10,912	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,379	6,379	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	111,183	111,183	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,195	5,195	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,313	1,313	32
33	V	25	OTHER ADMIN. STAFF TRANS.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	29	29	33
34	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,145	2,145	34
35	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	27,533	27,533	35
36	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,948	5,948	36
37	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,596	1,596	37
38	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	15,020	15,020	38
39	Total			$			$ 321,241	$ * 321,241	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	823	$ 823	15
16	V	19	CORP ALLOC/MGMT FEE	124,558	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	(124,558)	16
17	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			18
19	V	10	NURSE CONSULTANT		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			19
20	V	1	DIETICIAN SALARIES	4,740	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,504	(236)	20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	607	607	21
22	V	10A	RESPIRATORY THERAPIST	270	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(270)	22
23	V	43	MARKETING CONSULTANT	50	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(50)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 129,618			$ 5,934	$ * (123,684)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	INSURANCE	$	QUALITY CARE MANAGEMENT	100.00%	$ (102)	$ (102)	15
16	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	8,498	8,498	16
17	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	6,021	6,021	17
18	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	2,477	2,477	18
19	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	1,315	1,315	19
20	V	19	MGNT FEES-DIRECT ALLOC		QUALITY CARE MANAGEMENT	100.00%	124,558	124,558	20
21	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	52	52	21
22	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	(4,072)	(4,072)	22
23	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	2,079	2,079	23
24	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	12,378	12,378	24
25	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	1,972	1,972	25
26	V								26
27	V								27
28	V	17	CORPORATE ALLOCATION	171,989	QUALITY CARE MANAGEMENT	100.00%		(171,989)	28
29	V	21	COMPUTER SERVICES	24,000	QUALITY CARE MANAGEMENT	100.00%		(24,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 195,989			$ 155,176	$ * (40,813)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRIAN CLOCH	DIR OF OPER	MGMT	33.33%	SEE ATTACHED	7.11	10.93%	ALLOC. SAL	$ 219	39-7	1
2	BRIAN CLOCH	DIR OF OPER	MGMT	33.33%	SEE ATTACHED	7.11	0.11%	ALLOC. SAL	27,904	17-7	2
3	MIKE FILIPPO	ADMINISTRATIVE	ADMIN	33.33%	SEE ATTACHED	4.37	9.71%	ALLOC. SAL	18,752	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 46,875		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ADVANCED THERAPY AND REHAB, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						2,489	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						151,084	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 153,573	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						2,858	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						327	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						763	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 3,948	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	404,328	8	$ 18,054	$	39,231	$ 1,752	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	404,328	8	5,848		39,231	567	2
3	10	NURSING	PATIENT DAYS	404,328	8	92,189	90,660	39,231	8,945	3
4	10	SAL-NURSING-M. DEAL	PATIENT DAYS	404,328	8	134,295	134,295	39,231	13,030	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	404,328	8	31,517		39,231	3,058	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	404,328	8	74,422	74,422	39,231	7,221	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	404,328	8	231,575	231,575	39,231	22,469	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	404,328	8	90,333	90,333	39,231	8,765	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	404,328	8	200,000	200,000	39,231	19,406	9
10	17	ADMIN. SAL. - C. ROSS	PATIENT DAYS	404,328	8	118,071	118,071	39,231	11,456	10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	404,328	8	155,000	155,000	39,231	15,039	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	404,328	8	193,262	193,262	39,231	18,752	12
13	17	ADMIN. SAL. - J. ELOWE	PATIENT DAYS	404,328	8	36,364	36,364	39,231	3,528	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	404,328	8	112,461		39,231	10,912	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	404,328	8	65,740		39,231	6,379	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	404,328	8	1,145,893	1,000,220	39,231	111,183	16
17	21	SALARIES-ACCTG-B. LARIMO	PATIENT DAYS	404,328	8	53,541	53,541	39,231	5,195	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	404,328	8	13,535		39,231	1,313	18
19	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	404,328	8	300		39,231	29	19
20	26	INSURANCE	PATIENT DAYS	404,328	8	22,107		39,231	2,145	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	404,328	8	283,762		39,231	27,533	21
22	30	DEPRECIATION	PATIENT DAYS	404,328	8	61,299		39,231	5,948	22
23	32	INTEREST	PATIENT DAYS	404,328	8	16,452		39,231	1,596	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	404,328	8	154,799		39,231	15,020	24
25	TOTALS					$ 3,310,819	$ 2,377,744		$ 321,241	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	404,328	8	8,483		39,231	823	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	12,688	2	14,784	14,784			3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	12,688	2	1,994				4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	41,225	8	39,169	39,169	4,740	4,504	6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	41,225	8	5,282		4,740	607	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 69,712	$ 53,953		$ 5,934	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	INSURANCE	PATIENT DAYS	152,042	5	$ (394)	$ (394)	39,231	$ (102)	1
2	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	152,042	5	32,933	32,933	39,231	8,498	2
3	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	152,042	5	23,333	23,333	39,231	6,021	3
4	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	152,042	5	9,600	9,600	39,231	2,477	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	152,042	5	5,097		39,231	1,315	5
6	19	MGNT FEES-DIRECT ALLOC	DIRECT ALLOCATION		5	857,602			124,558	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	152,042	5	200		39,231	52	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	152,042	5	(15,781)		39,231	(4,072)	8
9	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	152,042	5	8,058		39,231	2,079	9
10	30	DEPRECIATION	PATIENT DAYS	152,042	5	47,971		39,231	12,378	10
11	32	INTEREST	PATIENT DAYS	152,042	5	7,643		39,231	1,972	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 976,262	$ 65,472		$ 155,176	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MANUFACTURERS BANK		X	MORTGAGE	$37,104.00	11/01/02	$	$ 4,437,000	11/01/32	PRIME	$ 203,034	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURERS BANK		X	LINE OF CREDIT	N/A	06/15/00	900,000	480,000		Prime +.5%	36,022	6
7	UNIVERSAL		X	INSURANCE FINANCING							4,357	7
8												8
9	TOTAL Facility Related				$37,104.00		$ 900,000	$ 4,917,000			$ 243,412	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										3,200	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,200	14
15	TOTALS (line 9+line14)						$ 900,000	$ 4,917,000			$ 246,612	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTERST INCOME						$	$			$ (368)	1
2	ALLOC. BOULEVARD MGMT	X									1,596	2
3	ALLOC. QUALITY CARE	X									1,972	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 3,200	21

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	43,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	81,978	2
3. Under or (over) accrual (line 2 minus line 1).	$	38,778	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	84,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	59	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 530 For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	122,837	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
1997	39,207	8
1998	39,811	9
1999	40,538	10
2000	42,040	11
2001	81,978	12

CALCULATION OF ACCRUAL = 2001 TAX x 1.02
81978 x 1.02 = 84000 (ROUNDED)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FOX RIVER PAVILION COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0038877

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-22-451-001	LONG TERM CARE PROPERTY	$ 77,678.76	$ 77,678.76
2.	15-22-451-002	LONG TERM CARE PROPERTY	$ 1,464.14	$ 1,464.14
3.	15-22-451-003	LONG TERM CARE PROPERTY	$ 1,464.14	$ 1,464.14
4.	15-22-451-004	LONG TERM CARE PROPERTY	$ 1,268.90	$ 1,268.90
5.	15-24-377-010	LONG TERM CARE PROPERTY	$ 102.12	$ 102.12
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 81,978.06	$ 81,978.06

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FOX RIVER PAVILION COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0038877

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,808 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 222,083
2. Number of Years Over Which it is Being Amortized: LOAN-12M
3. Current Period Amortization: 43,520
4. Dates Incurred: 2000

Nature of Costs: UNAMORTIZED MORTGAGE COSTS
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY			$ 344,850	1
2					2
3	TOTALS			$ 344,850	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	35,735		20	1,788	1,788	15,758	9
10	Various			1994	37,645		20	1,491	1,491	12,801	10
11	Various			1995	110,619		20	5,747	5,747	42,561	11
12	Various			1996	61,835		20	3,093	3,093	20,317	12
13	Various			1997	51,869		20	2,595	2,595	14,041	13
14	Various			1998	87,571		20	4,381	4,381	19,504	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		3,113,126	91,201		91,201		213,888	68
69	Financial Statement Depreciation			19,321			(19,321)		69
70	TOTAL (lines 4 thru 69)		$ 3,498,400	$ 110,522		$ 110,296	$ (226)	$ 338,870	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,498,400	$ 110,522		$ 110,296	$ (226)	$ 338,870	1
2	ELEV OP PANEL	1999	2,690		20	135	135	529	2
3	PUMP/BOILER REPAIR	1999	2,316		20	116	116	454	3
4	ROOF FANS	1999	2,900		20	145	145	508	4
5	DOOR	1999	1,696		20	85	85	298	5
6	ELEV OP PANEL	1999	2,690		20	135	135	461	6
7	TUCKPOINTING	1999	1,075		20	54	54	180	7
8	TANK REMOVAL	1999	2,670		20	134	134	503	8
9	CORDED STATION	1999	594		20	30	30	103	9
10	LIGHTING SUPPLIES	1999	1,198		20	60	60	215	10
11	VARIOUS REPAIRS	1999	683		20	34	34	122	11
12	VARIOUS REPAIRS	1999	1,938		20	97	97	323	12
13	FIXTURES	1999	603		20	30	30	122	13
14	DOORS	2000	1,948		20	50	50	140	14
15	CARPETING	2000	1,407		20	36	36	98	15
16	CHILLER COMPRESSOR	2000	19,800		20	508	508	1,291	16
17	PUMP REPAIR	2000	1,978		20	51	51	117	17
18	BOILER PUMP	2000	1,166		20	58	58	116	18
19	WALL COVERINGS	2000	722		20	36	36	72	19
20	BLINDS	2000	1,121		20	56	56	112	20
21	FIRE SPRINKLER	2000	576		20	29	29	58	21
22	PAINTING & DECOR	2000	2,834		20	142	142	284	22
23	REPLC & WELD HTG FLG	2001	1,019		20	26	26	34	23
24	DOOR INSTALLATION	2001	2,840		20	73	73	82	24
25	CARPET INSTALLATION	2001	1,079		20	28	28	29	25
26	DOOR	2001	663		20	33	33	66	26
27	WATER PUMP	2001	1,738		20	87	87	167	27
28	ELECTRICAL WORK	2001	1,895		20	95	95	150	28
29	LOCKS	2001	811		20	41	41	44	29
30	ELECTRICAL WORK	2001	2,595		20	130	130	152	30
31	INSTALL DOORS	2002	8,384		20	769	769	769	31
32	INSTALL DOORS	2002	1,438		20	108	108	108	32
33	INSTALL DOORS	2002	12,355		20	824	824	824	33
34	TOTAL (lines 1 thru 33)		$ 3,585,822	$ 110,522		$ 114,531	$ 4,009	$ 347,401	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,585,822	$ 110,522		$ 114,531	$ 4,009	$ 347,401	1
2	WALLPAPER	2002	2,086		20	1,391	1,391	1,391	2
3	INSTALL DOORS	2002	2,092		20	70	70	70	3
4	ROOF REPAIR	2002	5,775		20	241	241	241	4
5	FLUSH REPAIR	2002	786		20	39	39	39	5
6	NURSE CALL SYSTEM	2002	597		20	30	30	30	6
7	GENERATOR REPAIR	2002	3,305		20	165	165	165	7
8	FREEZER REPAIR	2002	784		20	39	39	39	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,601,247	$ 110,522		$ 116,507	$ 5,985	$ 349,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2000		$ 3,103,650	$ 90,000	35	$ 90,000	$	$ 212,687	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATED - BOULEVARD HEALTHCARE MANAGEMEN		2002		9,476	1,201	20	1,201		1,201	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A-REP, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,113,126	$ 91,201		$ 91,201	$	$ 213,888	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 323,301	$ 31,652	$ 38,813	$ 7,161	10	$ 155,605	71
72	Current Year Purchases	70,143	15,352	7,892	(7,460)	10	7,892	72
73	Fully Depreciated Assets	16,393				10	16,393	73
74								74
75	TOTALS	$ 409,837	$ 47,004	$ 46,705	$ (299)		$ 179,890	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	4,355,934	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	157,526	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	163,212	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	5,686	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	529,267	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	ALLOC - BOULEVARD				15,020			5
6								6
7	TOTAL				$ 15,020 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 5,906 Description: ICE MACHINE-900; WATER MACHINE-2013; GENERATOR RENTAL - $2170; ALLOC BLVD - $823
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 10,085	$		$ 10,085	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,064			13,064	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			171,668			171,668	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				33,095		33,095	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					4,502	90,134		94,636	13
14	TOTAL			$		$ 199,319	$ 123,229		$ 322,548	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	31,286	31,286	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	572,360	572,360	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,504	48,504	6
7	Other Prepaid Expenses	568	568	7
8	Accounts Receivable (owners or related parties)	174,989	174,989	8
9	Other(specify): See Supplemental Schedule		477,226	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 827,707	$ 1,304,933	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		344,850	13
14	Buildings, at Historical Cost		3,103,650	14
15	Leasehold Improvements, at Historical Cost	395,624	395,624	15
16	Equipment, at Historical Cost	301,167	301,167	16
17	Accumulated Depreciation (book methods)	(319,586)	(532,273)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		184,720	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,157)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	9,328	9,328	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 386,533	$ 3,800,909	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,214,240	$ 5,105,842	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 647,577	$ 734,332	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,286	31,286	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	105,430	105,430	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,841	10,841	31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,000	84,000	32
33	Accrued Interest Payable	14,577	14,577	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	784,373	48,419	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,678,084	$ 1,028,885	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	480,000	480,000	39
40	Mortgage Payable		4,437,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 480,000	$ 4,917,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,158,084	$ 5,945,885	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (943,844)	$ (840,043)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,214,240	$ 5,105,842	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (343,176)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (343,176)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(517,875)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(82,793)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (600,668)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (943,844)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,424,927	1
2	Discounts and Allowances for all Levels	(493,776)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,931,151	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	411,900	6
7	Oxygen	33,820	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 445,720	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49,366	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,047	19
20	Radiology and X-Ray	3,456	20
21	Other Medical Services	82,154	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 146,023	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	368	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 368	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	530	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 530	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,523,792	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	890,156	31
32	Health Care	1,804,702	32
33	General Administration	1,255,269	33
	B. Capital Expense		
34	Ownership	665,134	34
	C. Ancillary Expense		
35	Special Cost Centers	360,159	35
36	Provider Participation Fee	66,247	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,041,667	40
41	**Income before Income Taxes (line 30 minus line 40)****	(517,875)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (517,875)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,911	2,352	$ 66,130	$ 28.12	1
2	Assistant Director of Nursing	429	527	12,562	23.84	2
3	Registered Nurses	26,448	30,274	751,471	24.82	3
4	Licensed Practical Nurses	354	392	8,313	21.21	4
5	Nurse Aides & Orderlies	37,526	40,973	516,090	12.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,552	1,807	20,851	11.54	8
9	Activity Director	1,806	2,248	25,427	11.31	9
10	Activity Assistants	3,691	4,223	36,541	8.65	10
11	Social Service Workers	6,138	6,760	76,972	11.39	11
12	Dietician			14,803		12
13	Food Service Supervisor	1,979	2,297	37,911	16.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,643	17,547	121,508	6.92	15
16	Dishwashers					16
17	Maintenance Workers	4,773	5,502	74,395	13.52	17
18	Housekeepers	16,179	17,872	140,480	7.86	18
19	Laundry	8,821	9,721	72,002	7.41	19
20	Administrator	1,867	2,114	60,972	28.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,547	8,759	116,991	13.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,339	2,534	30,409	12.00	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,291	1,352	35,492	26.25	33
34	TOTAL (lines 1 - 33)	140,295	157,254	$ 2,219,320 *	$ 14.11	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	MONTHLY	11,588	09-03	36
37	Medical Records Consultant	44	1,820	10-03	37
38	Nurse Consultant	MONTHLY	1,650	10-03	38
39	Pharmacist Consultant	MONTHLY	5,348	10-03	39
40	Physical Therapy Consultant	26	1,170	10a-03	40
41	Occupational Therapy Consultant	29	1,283	10a-03	41
42	Respiratory Therapy Consultant	9	270	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	189	9,838	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	297	$ 32,967		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,169	$ 59,112	10-03	50
51	Licensed Practical Nurses	969	40,581	10-03	51
52	Nurse Aides	1,191	29,530	10-03	52
53	TOTAL (lines 50 - 52)	3,329	$ 129,223		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KEN BOGARD	ADMINISTRATOR	0	$ 60,972
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,972

B. Administrative - Other

Description	Amount
QUALITY CARE MANAGEMENT - MANAGEMENT FEES	$ 171,989
TOTAL (agree to Schedule V, line 17, col. 3)	$ 171,989
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Gardner, Carton & Douglas	Legal	$ 1,621
Sachnoff & Weaver	Legal	21,375
Seyfarth Shaw	Legal	987
Winston & Strawn	Legal	1,840
RSM McCladery	Consultant	435
Thomas Lechowitz	Accounting	200
Frost, Ruttenberg & Rothblatt	Accounting	35,924
Personnel Planners	Unemployment Consultant	738
See Attached	Computer	33,531
Documentation Solutions	Consultant	70
Bridgemark LLC	Mortgage Consultant	9,500
C. LTD	Architectural ConsultaNT	1,319
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 107,540

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,409
Unemployment Compensation Insurance	25,019
FICA Taxes	163,330
Employee Health Insurance	114,433
Employee Meals	21,221
Illinois Municipal Retirement Fund (IMRF)*	
401K EXPENSE	12,459
DISABILITY INSURANCE	11,854
EMPLOYEE BENEFITS	4,513
TOTAL (agree to Schedule V, line 22, col.8)	$ 402,238

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	10,954
Health Care Worker Background Check	1,000
(Indicate # of checks performed 100)	
ICLTC DUES	6,164
LICENSES	164
ADVERTISING AND YELLOW PAGE	39,655
DUES	1,068
ALLOC - QUALITY CARE	52
ALLOC - BOULEVARD	6,379
Less: Public Relations Expense	(33,996)
Non-allowable advertising	( )
Yellow page advertising	(5,659)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,181

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,487
ALLOC - BOULEVARD	1,313
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,800

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC - $6,764.00**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **675** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,247**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,221** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees